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FY 2020-21
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SANTA CLARA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

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INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review, or a desk review, of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also considers the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Santa Clara MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

MHP Information

MHP Size — Large

MHP Region — Bay Area

MHP Location — San Jose

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 24,232

MHP Threshold Language(s) — Spanish, Vietnamese, Mandarin, Tagalog, Cantonese, Farsi

CalEQRO obtained the MHP threshold language information from the DHCS Behavioral Health Information Notice (BHIN) 20-070.

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of the MHP's Electronic Health Records (EHR), Information Technology (IT), claims, outcomes, and other reporting systems and methodologies for calculating PMs.

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to 42 CFR Part 438.68. In addition, the California State Legislature passed Assembly Bill (AB) 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and BHINs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standards (AAS), and Rendering Provider

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS BHIN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS reviews these forms to determine if the provider networks meet required time and distance standards, as well as timeliness standards, for essential mental health (MH) services and psychiatry services for youth and adults. If these standards are not met, DHCS requires the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, CalEQRO will review the AAS and ONA information as part of its annual EQR.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

Validation of State and MHP Beneficiary Satisfaction Surveys

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CalEQRO also conducted 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

The CalEQRO review draws upon prior years' findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following five domains: access to care, timeliness of services, quality of care, beneficiary

progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2019-20

PIP Recommendations

Recommendation 1: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. The completed clinical PIP leaves space for the next clinical PIP, which needs to be created and executed as soon as possible. Please contact CalEQRO for TA early and often.

Status: Met

- The MHP began work in early 2020 on a clinical PIP to develop interventions to engage older adult beneficiaries from underrepresented racial/ethnic groups in specialty MH services.
- The MHP engaged CalEQRO in development of this PIP and received Technical Assistance (TA).

- Due to the multiple engagement challenges, particularly with older adults, presented by the COVID-19 Public Health Emergency, the MHP determined that the context would hamper the ability to implement and evaluate the effectiveness of the PIP's interventions.
- Simultaneously, the use of telehealth as a delivery method increased, presenting an opportunity to pilot the Same Day Access Assessment study.
- Based on these developments, the MHP chose to pause the above clinical PIP and to initiate a new clinical PIP (title: Same Day Access). The PIP teams are currently working on this PIP and receiving TA from Cal EQRO.
- The MHP continues to send all PIPs to CalEQRO for feedback and engages in TA on a routine basis.

Recommendation 2: Follow-up with recommendations from EQRO for the non-clinical PIP and seek TA from EQRO as it progresses.

Status: Met

- The CalEQRO FY2019-20 Final Report recommended that the MHP develop a data analysis plan inclusive of a re-measurement strategy. It also recommended that the MHP continue the PIP project "at least six to nine months" to show change over time.
- The MHP incorporated both recommendations into its practices, adopting a monthly remeasurement interval and continuing the PIP during this review period.
- The MHP participated in CalEQRO TA various times over the time between CalEQRs.

Access Recommendations

Recommendation 3: Determine the reasons for beneficiaries remaining in care for extended periods when they are viewed as clinically ready to step down to the next level of care. Specifically, examine the extent to which Community Based Organizations (CBO) hiring and retention issues and MHP process issues are contributing to capacity issues in moving beneficiaries on when they are clinically ready.

Status: Partially Met

- The MHP expanded its continuum of outpatient care for adults and older adults by instituting and/or expanding slots for intensive outpatient services. This includes Full-Service Partnership (FSP), Intensive

Full-Service Partnership (IFSP), Assertive Community Treatment (ACT), and Forensic Assertive Community Treatment (FACT).

- This expansion increased services to support beneficiaries exiting institutions for mental diseases (IMDs) and other 24-hour levels of care. To help ensure that the service system has a dynamic capacity to tailor treatment slots of the correct variety to meet current demand, the MHP instituted quarterly meetings with the Certified Contract Providers (CCPs) to examine the utilization of the continuum of services offered by each CCP versus the needed capacity (demand for services). The MHP provided data in these meetings to support CCPs in submitting Program Modification Requests to move budgeted funds from underused program areas to target programs that needed more capacity.

- Acknowledging the role of stable housing in successful discharges from IMD, the MHP has also been working to acquire additional Residential Care Facility (RCF) beds. These beds are managed by the Intensive and Residential Services Team, which has instituted updated tracking mechanisms allowing for more streamlined movement across levels of care. Additionally, the Intensive and Residential Services Team collaborates with the County Public Guardian's Office to ensure collaborative decision-making on level of care changes, specifically those that impact Lanterman-Petris-Short conserved consumers.

- The MHP did not specifically address the hiring and retention issues in their response. The MHP did not examine the extent to which CBO hiring and retention issues are contributing to capacity issues in moving beneficiaries on when they are clinically ready.

- The support for contract providers moving budget from underused program areas to target programs that needed more capacity is promising in allowing for more capacity.

- The recommendation was not limited to IMDs, but other treatment levels were not addressed. In terms of numbers, beneficiaries held in outpatient MH services beyond their need because of limitations on services for mild-to-moderate is likely a larger problem.

- While the MHP addressed capacity issues in the ways explained above, there was no information on whether the MHP researched reasons for beneficiaries remaining at a specific level of care and not stepping down when clinically determined to be ready.

Recommendation 4: Continue working on improving the accuracy of determination of level of care (LOC) needs and geographic location (of clinic and beneficiary) for new intakes at the Access Call Center by providing staff with additional training on the new screening tool and improving the tool's

alignment with current beneficiary status as well as previous, historical acuity and services. (This recommendation is a carry-over from FY 2018-19.)

Status: Met

- The MHP developed an Integrated Screening Tool (IST) for the call center to help with placing the beneficiary into the most appropriate level of care (LOC) at the time of initial request for services.
- To refine LOC determinations at assessment, the MHP has implemented the Daily Living Activities 20 (DLA20) which can be used both as an outcomes and LOC tool for adults/older adults.

Recommendation 5: Improve collaboration with Managed Care Organizations (MCOs) for transitioning mild-to-moderate beneficiaries once stabilized or create a Memorandum of Understanding (MOU) between the MCOs and the MHP for contract providers to continue serving mild-moderate beneficiaries, billing MCOs rather than Short-Doyle Medi-Cal (SDMC). (This recommendation is a carry-over from FY 2018-19.)

Status: Met

- The MHP has established strategies for stepping beneficiaries down to or supporting beneficiaries in maintaining their MH treatment in non-specialty levels of care, including embedding MHP employees in primary care, e.g., Federally Qualified Health Centers (FQHC) settings, and directly operating a limited mild to moderate outpatient MH clinic.
- The MHP participates in quarterly Joint Operations Committee (JOC) meetings with the Santa Clara Family Health Plan (SCFHP) to maintain and improve communication and data sharing between the two entities, and to review and update workflows for stepping consumers down to primary care.
- An MOU exists between the MHP and SCFHP that outlines care coordination responsibilities.
- The MHP is in discussion with Valley Health Plan (VHP) regarding the enhancement of their mild-to-moderate network inclusive of strategies to ensure that the correct entity (MCO versus MHP) is billed for care.

Timeliness Recommendations

Recommendation 6: Consider reducing the 5-day expectation for completion of service/progress notes in the clinical record to within two days.

Status: Partially Met

- Given implementation of a new Electronic Medical Record (EMR) this year, the MHP concluded that focusing on training clinical staff on new forms and clinical workflows in myAvatar was a prerequisite to initiating a change in the timely documentation completion requirements.

- The EMR implementation team reviews reports on completion rates of progress notes and other documents as a metric for adoption of and proficiency with the new EMR.

- The MHP endorses requiring progress notes finalization within a shorter time and is working with the documentation training/review team to stage rolling out new standards. No timeline for this training and roll out was given to CalEQRO.

Recommendation 7: Ensure consistency between Network Adequacy and Timely Access Policy and Procedures, approved April 2018, and MHP reported timeliness metrics for offered and kept appointments for initial access and first psychiatry appointments. (This recommendation is a carry-over from FY 2018-19.)

Status: Met

- The MHP has adopted the Federal Medi-Cal Managed Care timeliness requirements, thereby assuring consistency between the Network Adequacy Certification (NACT) and the MHP Assessment of Timely Access (MATA).

- The MHP is consistently capturing and reporting these data to demonstrate system performance and to track the impact of improvement processes.

- With the implementation of the new EMR, clinicians can now document the date a client is referred for psychiatry in a defined field. This enhancement allows for improved ability to report on this metric.

Recommendation 8: Provide clear direction to psychiatrists and other clinicians on the need for accurate no-show information, as this can potentially shed a light on unused capacity. Implement myAvatar Scheduler functionality to facilitate capturing no-shows and other timeliness information.

Status: Met

- The MHP reported that the implementation of myAvatar now assures that all no-show and cancellations can be recorded and reported on throughout engagement with the clients.

- There are presently service selections in myAvatar for all service types that indicate each of three possible missed appointments: “No-Show”;

"Client Cancelled"; and "Clinician Cancelled". When entering notes for service types, all staff have been trained and instructed to select the appropriate missed visit reason for the corresponding intended visit type.

- The records of these missed visits are then captured in the system and can be reported out upon based on a variety of factors such as staff, program, client, service type, date range, etc.
- This setup in the system will provide clear information for psychiatry services, as well as other services, to assist in the evaluation of unused capacity, manage staff time efficiently, as well as to assess various levels of engagement.
- Information on no-shows in the current MATA does not yet reflect myAvatar data so this is a follow-up for next year's EQRO review.

Quality Recommendations

Recommendation 9: Establish a clear policy of documenting co-occurring MH and substance use disorders (SUD) and provide for a clear and easy to execute procedure for documenting them to report a more accurate co-occurring disorders rate.

Status: Met

- The MHP reports that documenting co-occurring disorders remains the policy and practice of the MHP. The MHP Clinical Practice Guidelines Manual addresses evaluation of SUDs.
- In reviewing the guidelines at https://www.sccgov.org/sites/bhd-p/QI/MH-QA/Documents/BHSD-Practice-Guidelines-Manual-09182020.pdf, this manual speaks to the importance of assessing for SUD, potential referrals, and the importance of administering an SUD assessment.
- MHP clinical staff are required to take 42 CFR training as well as training on the American Society of Addiction Medicine (ASAM) and Stages of Change best practice models.
- The MHP has modeled the Integrated Behavioral Health Assessment into the EMR. The ASAM Society of Dimensions and the Stages of Change model are integrated into the assessment. Immediately after completing these portions of the assessment, the clinician is presented with the opportunity to update the diagnosis. It is hoped, and not yet verified, that this will increase the accuracy of the reporting of co-occurring disorders.

Beneficiary Outcomes Recommendations

Recommendation 10: Actively solicit peer employee and beneficiary feedback on access, timeliness, and quality of services, and utilize this information to make program and resource changes, as indicated. (This recommendation is a carry-over from FY 2018-19.)

Status: Partially Met

- The MHP presents findings on access, timeliness, and quality of care to several different entities, such as the Behavioral Health Board, the Cultural Competency Sub-Committee, and Behavioral Health Quality Improvement Committee for feedback and recommendations. These committees all include representation from contractors, county staff, beneficiaries, and family members.
- In 2020 a new Director of Consumer and Family Affairs position was filled, and Quality Management is working with this Division Director to develop strategies to increase the collaboration between these two functions.
- Activity to address this recommendation continues to be in process, due to COVID-19 pandemic responses and changes in the MHP's workflows.

Foster Care Recommendations

None noted.

Information Systems Recommendations

Recommendation 11: Provide CBOs with regular detailed information about the timing of the CBO integration with myAvatar, and the expectations the MHP has for the CBOs and their system vendors' preparation and training for the transition.

Status: Met

- The MHP Executive Team meets monthly with the Behavioral Health Contractor's Association (BHCA), an association of the Directors of more than 30 non-profit organizations that provide mental health and substance use services in the County of Santa Clara.
- Information regarding the timing of the Go-Live for County operations in addition to the Go-Live for CCPs on Provider Connect Enterprise (PCE) and Provider Connect NX Portal (PCP) has been disseminated in these meetings as well as via memos. (The MHP provided to CalEQRO copies of memos in submitted documentation for the review.)
- Key members of the Netsmart project team responsible for the PCE/PCP integration and Go-live have met extensively with the CCPs and their

Electronic Medical Record (EMR) vendors to provide technical specifications, requirements, and project plans.

Recommendation 12: Reactivate the EHR User Groups before the myAvatar Go-live in July 2020. Consider the following user groups: Billing, Reports, Clinical, and Clerical.

Status: Met

- Restarting the EMR User Groups mirrored the Go-Live calendar.
- Prior to Go-Live a Super User Group with representatives spanning clinical, administrative, and technical functions was trained and deployed to support the Go-Live, to provide ongoing end user support and to elevate issues identified among the end users.
- A Governance Structure for the EMR Implementation was developed and put in place including: an Executive Oversight Committee, a Change Management Group to set standards and priorities and to intake optimization requests, as well as a Super User group to identify and troubleshoot issues and to increase/enhance EMR adoption.
- A separate county Billing Group began meeting weekly in the Fall, while the CCP billing group is scheduled to commence meetings in Q1 CY 2021.

Recommendation 13: Evaluate the information systems, and possibly other, employee resources that will be needed to effectively support myAvatar after the system is accepted and the Netsmart resources leave. Also, consider which Netsmart resources it will be necessary to retain and for how long until local resources are sufficient to support the system.

Status: Met

- The MHP executed a third amendment to the Netsmart contract in May 2020. This amendment extended the Netsmart engagement through December 2021 to support various aspects of the County and CCP Go-Lives.
- The County Technology and Support Services (TSS) have added a Technology Project Manager and Netsmart Training Lead positions.
- A new Behavioral Health Services Department (BHSD) Executive position over Analytics & Reporting has been filled, new Business Intelligence and Data Analyst positions are being filled, and a portion of the BHSD analyst workforce has been re-aligned to report under this position.

- A BHSD Billing Remediation Team has been created to work routine and ad hoc error reports, with assistance from the Health Information Management (HIM) team.

- This is notable progress in supporting the MHP's myAvatar implementation. The MHP is encouraged to reevaluate the adequacy of its resources in this area as the December 2021 end of the Netsmart engagement approaches.

Recommendation 14: Identify a member of the leadership team to have the overall leadership role for information technology and services.

Status: Met

- The BHSD Deputy Director over Managed Care partners closely with the TSS Director of Healthcare Technology, and, as such, holds the BHSD leadership role that has ultimate authority and responsibility for information and technology.

- Given the complexity of the interface between BHSD and TSS, including the current Netsmart myAvatar implementation, multiple BHSD Executives have provided primary support to the project, including the Director of Analytics & Reporting, who has served as Clinical Project Manager.

- This Director oversees a portion of the TSS staff work via a dotted line reporting relationship.

Recommendation 15: Determine what changes occurred that caused the disallowance rate for MHP Clinical Records Reviews to go from about five percent historically to more than 20 percent in the most recent review. Identify and execute the steps necessary to reduce the disallowance rate across the system of care (SOC)to five percent or less.

Status: Met

- The FY 2018-19 to FY 2019-20 year over year disallowance rate is more nuanced than is suggested by this recommendation. Seen in total, the overall disallowance rate decreased by more than 30 percent from one year to the next.

- Some CCPs did have higher disallowance rates in FY 2019-20 – these tended to be CCPs that were relatively newer to Medi-Cal documentation and/or had less robust internal auditing practices.

- To continue to support compliant Medi-Cal documentation the MHP:

    - restarted monthly documentation trainings,

- assigned one Quality Improvement Coordinator staff to each CCP to provide consistent technical assistance and training,
- published an updated Practice Guidelines Manual in September 2020, and
- began consistently joining the BHCA Quality Improvement meetings to provide information and assistance.

Recommendation 16: Investigate why 51 percent of Medi-Cal claims ($15M) denied were denied because of no prior authorization found or authorization expired (Void/Replace condition) and take action to correct the problem.

Status: Met

- The MHP reviewed and determined that these denials were associated with claims generated by CCPs. Issues associated with turnover of CCP administrative staff and a legacy claiming system (Unicare) allowed some services to be re-billed after successful adjudication and payment.
- The County Patient Business Services (PBS) Team provides ongoing training and technical assistance to CCPs, which includes providing monthly reports to CCPs of their denials with detailed instructions for working the denial reports.
- As evidenced by the CY2019 denial codes provided by the CalEQRO's and the MHP's reports, this issue no longer ranks among the top denial reasons.

Recommendation 17: Include in the myAvatar implementation plan an electronic interface to Quest for specialty laboratory orders and results. (This recommendation is a carry-over from FY 2018-19.)

Status: Met

- The MHP continues to use the county laboratory to fulfill the majority of its lab orders.
- Medical staff continue to write electronic orders for these labs through HealthLink (EPIC).
- An electronic interface with Quest for specialty orders is on the optimization list with Netsmart.

Recommendation 18: Develop a strategy to share clinical information with service providers, whether through a health information exchange (HIE) or another vehicle. (Part of this recommendation is a follow-up from FY 2017-18 and FY 2018-19.)

Status: Met

- During Phase-2 of the Netsmart myAvatar implementation (Q1 CY 2021) CCPs will be implementing one of two Netsmart products to support information sharing: ProviderConnect Enterprise (PCE) (24 CCPs) or ProviderConnect NX Portal (PCP) (4 CCPs).
- While both products support health information exchange, PCE utilizes Application Programming Interface (API) web services to securely share meaningful data between BHSD's EMR and CCPs' EMR.
- This solution leverages Fast Healthcare Interoperability Resources (FHIR) APIs defined and maintained by HL7. Information exchanged will include, but not be limited to, Client Admission and Registration, Client Demographics, Financial Eligibility, and Diagnosis information.
- CCPs and EMRs opting not to utilize the PCE solution will still be able to send and receive information through a portal, albeit using a more manual process.
- Continuity of Care Documents (CCDs), screenings, referrals and other relevant clinical documents will be accessible via the secure messaging via CareConnect Inbox.

Structure and Operations Recommendations

Recommendation 19: Review the impact on the CBOs of the current policy of returning contract dollars allocated to CBOs to the MHP if the program is performing under capacity and determine if it is achieving the intended results.

Status: Partially Met

- While the MHP has not routinely been successful in securing return of contract dollars from CCPs, the MHP is committed to "right sizing" contracts to optimize use of financial resources.
- The MHP Executive Team has engaged the CCPs in a series of meetings to collaboratively identify targets for County General Funds (CGF) reduction, focusing on multiple areas, including unexpended contract allocations.
- Due to costs of responding to the COVID-19 public health emergency and other related budgetary realities, the MHP received a directive from the County Executive's Office (CEO) to reduce utilization CGF.
- CalEQRO notes that while this recommendation is not met, it will not be carried forward due to the reasons presented by the MHP.

Recommendation 20: Implement a system to improve communication between Quality Improvement (QI) and CBOs that includes CBOs routinely bringing forward issues and receiving answers from the MHP, and regular meetings with collaborative discussion between all stakeholders.

Status: Met

- The MHP continues to host quarterly Quality Improvement Committee (BHQIC) meetings.
- The BHCA hosts monthly QI meetings, and extended invitations to attend to MHP Quality Management (QM) leaders. Attendance by QM leaders started in early Fall and has proven an effective forum for communication.
- Additional strategies include partnering a designated Quality Improvement Coordinator with each CBO to establish a stable technical assistance relationship.
- The MHP is revamping written communication strategies (including use of the external-facing website) to provide CBOs with timely and comprehensive information.

Recommendation 21: Establish an Access Call Center referral log that will enable the staff to resend a referral to a contract provider upon request or, better, allow the contract provider to look up the referral on-line. (This recommendation is a carry-over from FY 2018-19.)

Status: Met

- The MHP has implemented CareConnect Inbox (CCInbox) as part of the myAvatar implementation. CCInbox allows the Access Call Center to send referrals inclusive of screening results and additional demographic and clinical information via a secure messaging system.
- During Phase 2 of the Go-Live, CCPs that implement PCE or PCP will receive this information directly in their EMR or a portal application. (See response to recommendation 18 above).

Recommendation 22: Develop a sustainable and predictable approach to improving pay equity for CBO employees to improve access to care, timeliness of service delivery, and quality of care. Scheduled cost-of-living allowance (COLA) increases for CBOs built into their contracts would serve to recognize their importance to the MHP's ability to deliver timely and high-quality services.

Status: Not Met

- The financial projections for the County have been impacted by COVID-19 and the County Executive's Office has taken multiple steps to stabilize the budget.
- Certain unfilled classified positions have been deleted, and the County instituted a Voluntary Separation Incentive Program (VSIP), allowing staff to submit applications to receive incentive payments to separate from County service by early March 2021.
- Given this county operating environment, the MHP is unable to schedule routine increases to contracts and to recommend the CCPs apply those increases to employee COLAs.
- Specific to COVID-19: Three CCPs were approved for the Federal Paycheck Protection Program (PPP), while seven others were ineligible due to size.
- Other CCPs have explored loan programs to cover the gaps between cost and revenue due to periods of decreased service provision. Some of the CCPs have received "bridge payments" from the County -- forgivable loans to cover costs during the public health emergency.
- The financial impact of COVID-19 on the County's finances made it impossible to address this recommendation at this time.
- CalEQRO notes that the MHP was unable to address this recommendation due to issues stated above.

Recommendation 23: With hiring and retention, especially at the clinic level, being a continuing issue, review the extent to which the MHP's hiring process is confusing potential applicants or so slow that they take other offers first.

Status: Met

- Since late 2018, Employee Services Agency (ESA)—the County Human Resources Department -- has been undergoing a reorganization to streamline its recruitment and classification processes.
- In 2020, as a continuation of this work, the ESA launched County Leadership and Transformation Rapid Transformation Teams with three county departments with large recruitment pipelines, including BHSD. This project was supported by Behnam Tabrizi with Stanford's Department of Management Science and Engineering.
- This Rapid TransformationTeam, which aims to improve communication and timeliness of recruitments, is currently focused on improving clinic-level recruitments for Marriage and Family Therapists, Psychiatric Social

Worker and Rehabilitation Counsel classifications, as well as some Program Manager Classifications.

PERFORMANCE MEASURES

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to screenings, assessments, home-based mental health services, outpatient services, day treatment, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. SB 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf
2. EPSDT POS Data Dashboards: https://www.dhcs.ca.gov/provgovpart/pos/Pages/default.aspx
3. HEDIS Measures and Psychotropic Medication: http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx and http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
    - 5A (1&2) Use of Psychotropic Medications
    - 5C Use of Multiple Concurrent Psychotropic Medications
    - 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure
4. AB 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf
5. *Katie A. v. Bonta*:
   The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act Suppression Disclosure

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11, and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

Table 1 provides details on beneficiaries served by race/ethnicity.

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

Santa Clara MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	44,481	11.3%	4,790	19.8%
Latino/Hispanic	171,578	43.6%	11,200	46.2%
African-American	12,490	3.2%	1,313	5.4%
Asian/Pacific Islander	112,609	28.6%	3,175	13.1%
Native American	1,187	0.3%	119	0.5%
Other	50,853	12.9%	3,635	15.0%
Total	**393,195**	**100%**	**24,232**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

Table 2 provides details on beneficiaries served by threshold language identified in DHCS Mental Health Services Division Information Notice 13-09, which was considered current policy on threshold languages at the start of FY 2020-21. On December 14, 2020, DHCS issued Behavioral Health Information Notice (BHIN) 20-070 which utilizes more current Medi-Cal eligibility data to determine threshold languages. The MHP adheres to more recent Medi-Cal eligibility data, consistent with DHCS BHIN 20-070, wherein Cantonese is identified as a threshold language.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

Santa Clara MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	5,773	23.8%
Vietnamese	1,203	5.0%
Mandarin	119	0.5%
Tagalog	81	0.3%
Other Languages	17,056	70.4%
Total	**24,232**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

Penetration Rates and Approved Claims per Beneficiary

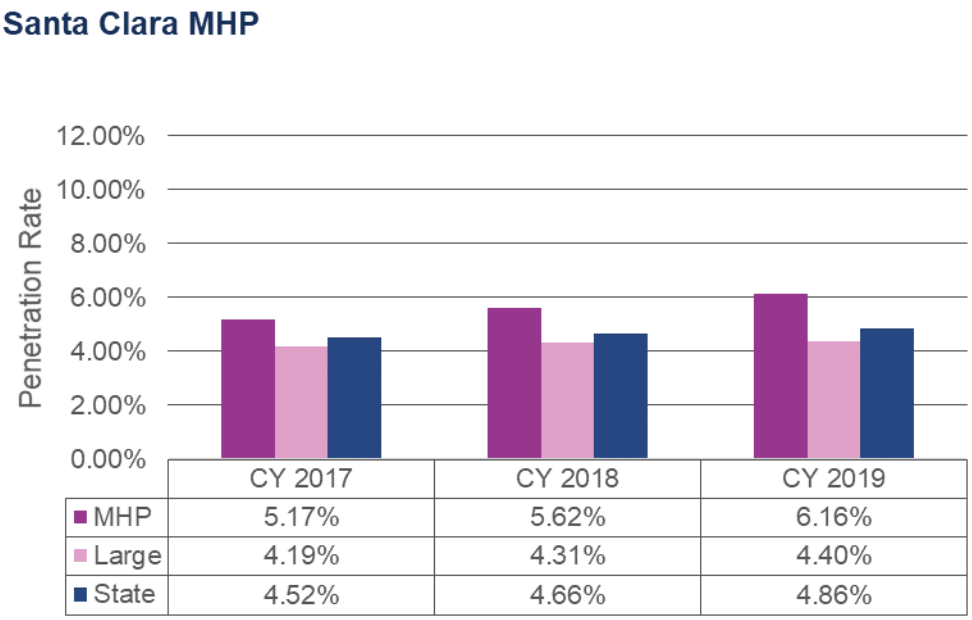
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2019. See Table D1 for the CY 2019 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the Santa Clara MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19)

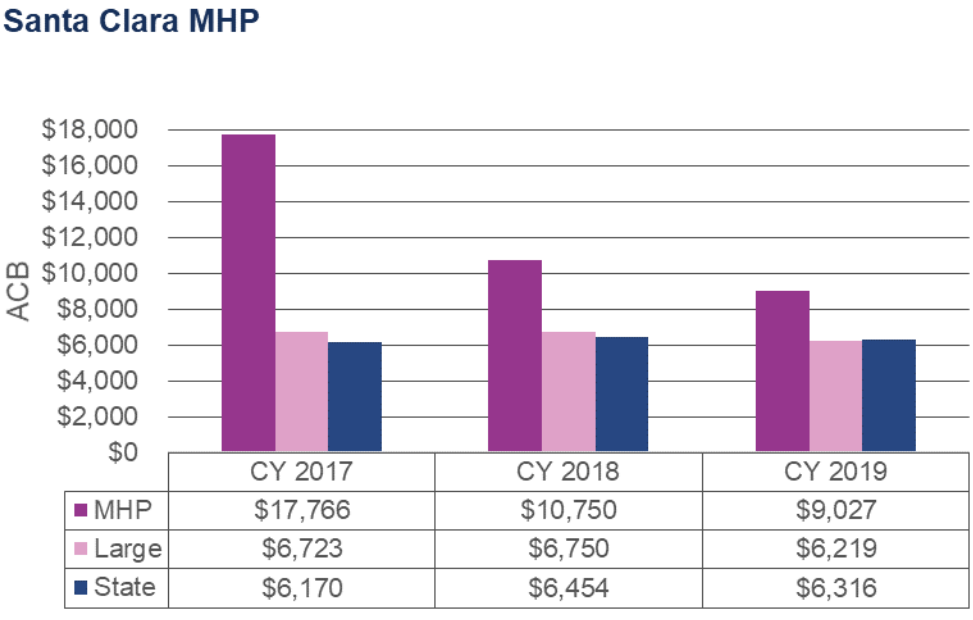
trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	5.17%	5.62%	6.16%
Large	4.19%	4.31%	4.40%
State	4.52%	4.66%	4.86%

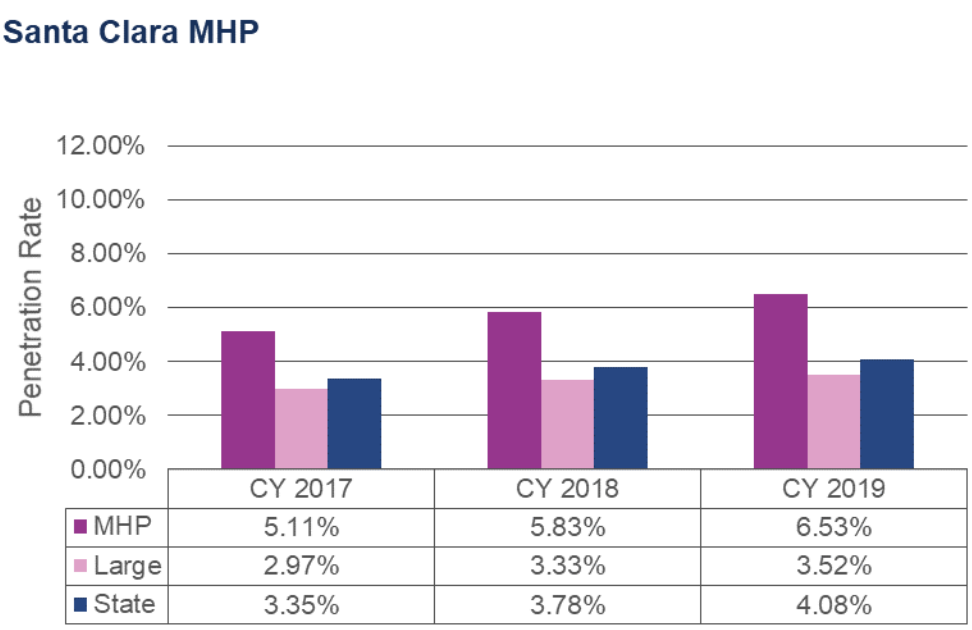
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$17,766	$10,750	$9,027
Large	$6,723	$6,750	$6,219
State	$6,170	$6,454	$6,316

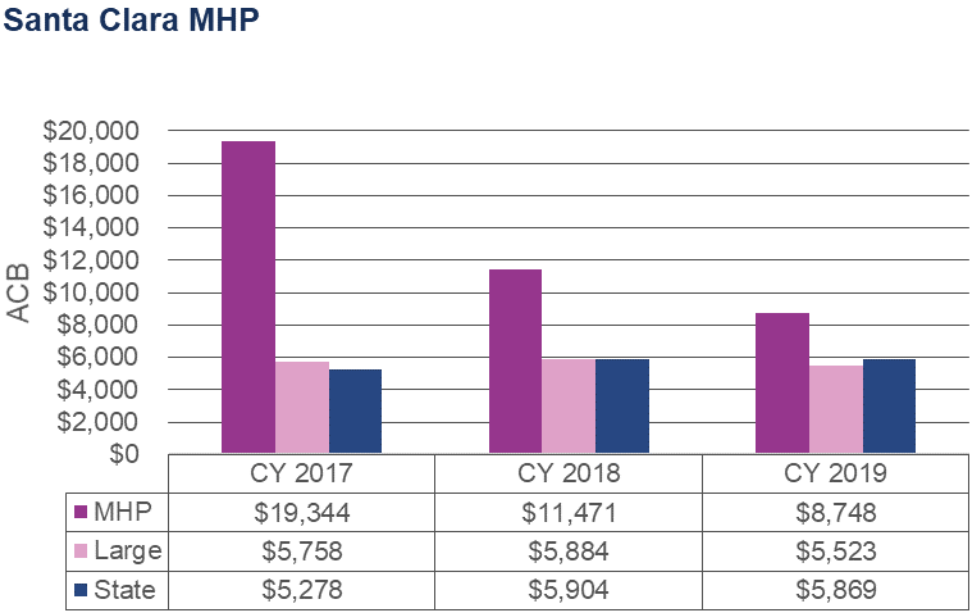
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	5.11%	5.83%	6.53%
Large	2.97%	3.33%	3.52%
State	3.35%	3.78%	4.08%

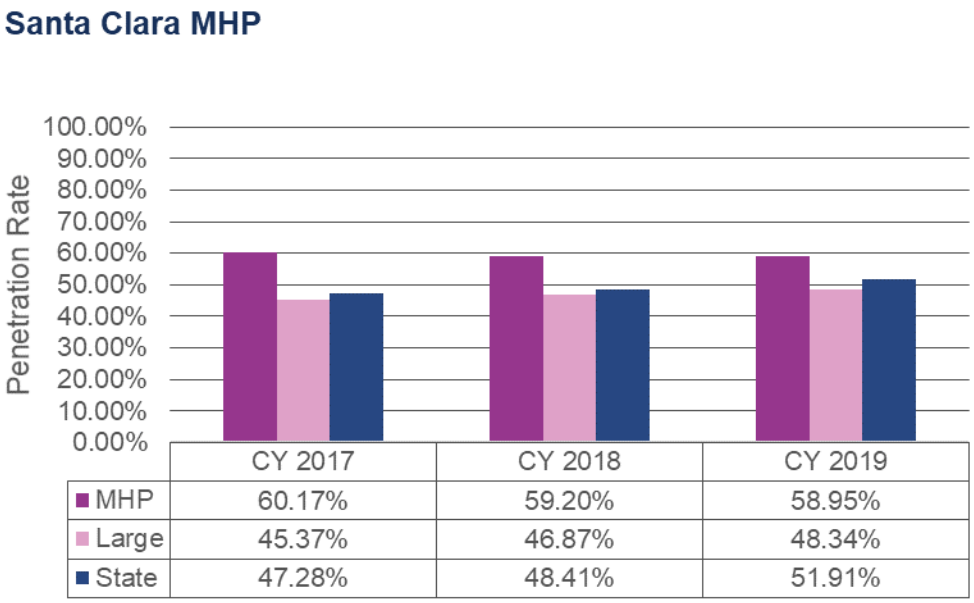
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$19,344	$11,471	$8,748
Large	$5,758	$5,884	$5,523
State	$5,278	$5,904	$5,869

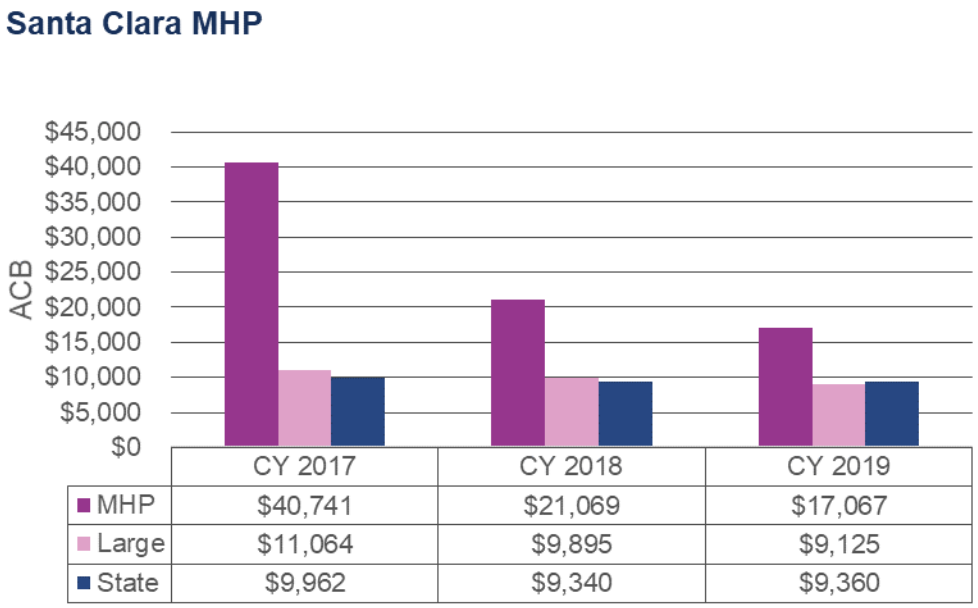
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	60.17%	59.20%	58.95%
Large	45.37%	46.87%	48.34%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

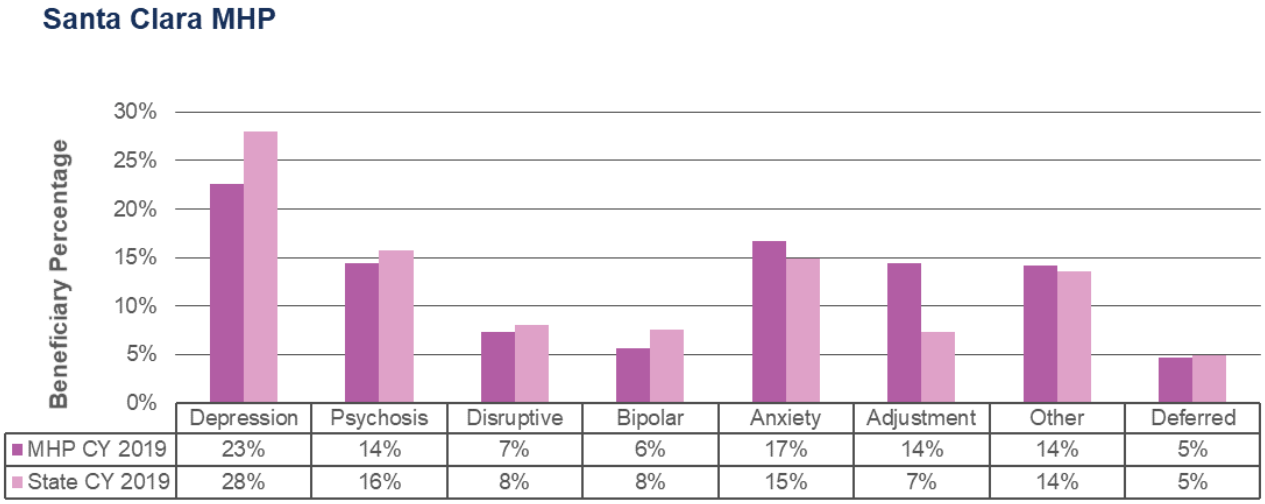


	CY 2017	CY 2018	CY 2019
MHP	$40,741	$21,069	$17,067
Large	$11,064	$9,895	$9,125
State	$9,962	$9,340	$9,360

Diagnostic Categories

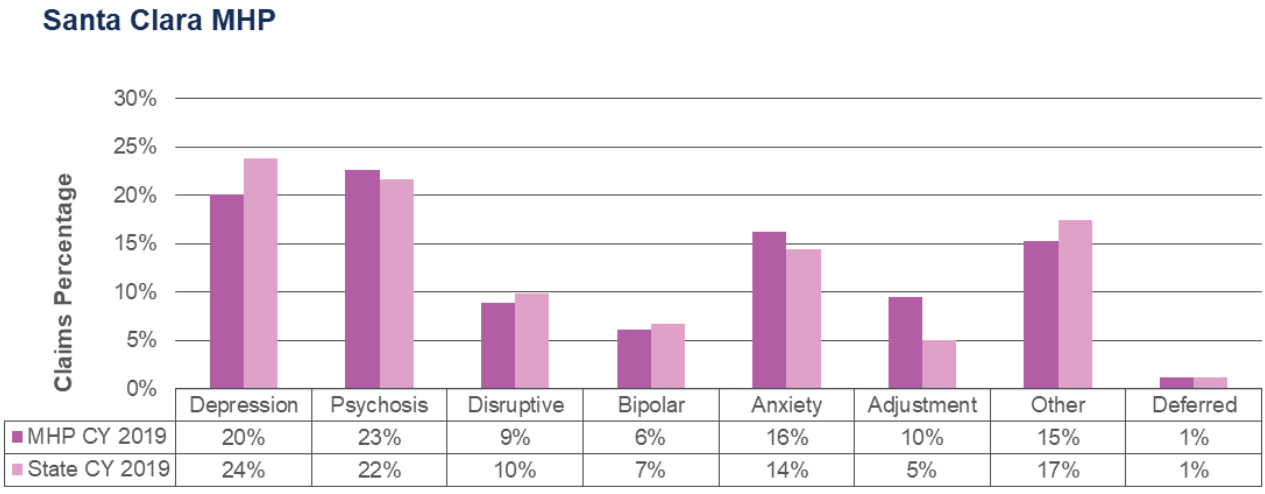
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	23%	14%	7%	6%	17%	14%	14%	5%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	20%	23%	9%	6%	16%	10%	15%	1%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

Santa Clara MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	1,400	24,232	5.78%	$53,493	$74,889,958	34.24%
	CY 2018	1,742	23,158	7.52%	$54,593	$95,100,344	38.20%
	CY 2017	3,801	22,520	16.88%	$61,198	$232,615,448	58.14%

See Attachment E, Table E1 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

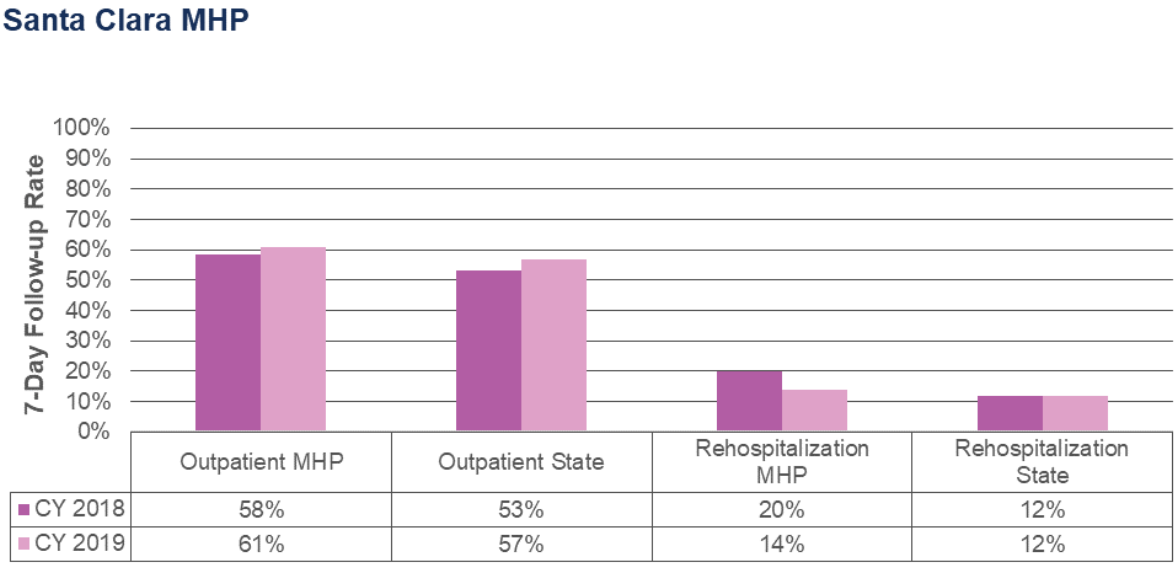
Table 4: Psychiatric Inpatient Utilization CY 2017-19

Santa Clara MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	950	1,991	10.28	7.80	$15,434	$10,535	$14,662,179
CY 2018	1,343	2,882	10.03	7.63	$13,755	$9,772	$18,473,616
CY 2017	1,064	2,047	9.38	7.36	$14,477	$9,737	$15,403,705

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

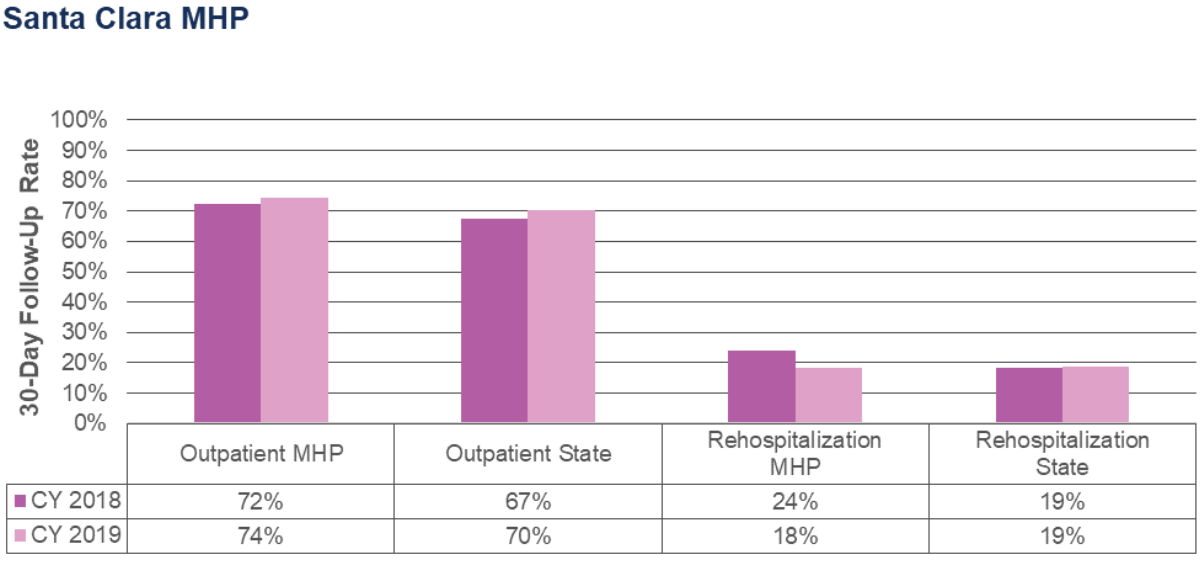
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	58%	53%	20%	12%
CY 2019	61%	57%	14%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	72%	67%	24%	19%
CY 2019	74%	70%	18%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

Santa Clara MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed two PIPs and validated two PIPs, as shown below.

Table 5: PIPs Submitted by Santa Clara MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	"Same Day Assessment for Adult/Older Adult: Pilot"
Non-Clinical	1	"Beneficiaries' Timeliness to Access and Treatment Services"

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Santa Clara
PIP Title	"Same Day Assessment for Adult/Older Adult: Pilot"
PIP Aim Statement	"Will providing same-day assessments for adult/older adults (A/OA) through a telehealth pilot MHP clinic result in improved access and engagement in services by at least 80 percent of beneficiaries receiving an assessment within ten days of the request for services, from December 2020 to May 2021 for the pilot clinic?"
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic)	

MHP Name	Santa Clara
☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17) * ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The study will initially focus on adult beneficiaries ages 18 and over, calling the MHP 24-hour call center number to request mental health services treatment.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): The beneficiary will be connected and introduced, via a three-way call, with the MHP clinic front desk staff for an assessment while on the call.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Beneficiaries will be offered an appointment on the same day or next business for a first assessment and a first treatment within 72 hours of assessment.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Beneficiaries will receive services via telehealth. Same Day Access (SDA) entails receiving a telehealth assessment on the day of request, Monday through Thursday, or the next business day if referred after 3:30 pm Monday through Wednesday.

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Total number of beneficiaries seen within ten business days *(number of persons seen within 10 days/number of referrals)*	9/1–11/30 2020	County Clinics 218/646 = 34% Pilot Clinic n/a	12/2020 (one month) ☐ n/a[5]	County Clinics: 110/275 =40% Pilot Clinic:29 /44 = 66%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
Total number of beneficiaries that kept their first scheduled appointment *(number of persons that were admitted to first assessment appointment /number of persons referred?)*	9/1-11/30 2020	County Clinics 470/541 = 87% Pilot Clinic: 89/124 = 72%	12/2020 (one month) ☐ n/a	County Clinics: 186/280 =66% Pilot Clinic: 26/45% = 58%	☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
Initial treatment appointments		Data not available	Data not available		☐ Yes ☐ No	☐ Yes ☐ No

[5] PIP is in planning and implementation phase if n/a is checked for all performance measures.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
scheduled and attended *(number of persons who kept appointment/number of persons with an appointment?*	9/1-11/30 2020	at this time	at this time ☒ n/a			p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	

Was the PIP validated?	☒ Yes ☐ No

Validation phase:	PIP status (per DHCS requirement):
☒ Implementation phase	Active and Ongoing
☐ Baseline year	
☐ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in XX months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active
☐ Planning phase	
☐ Other, inactive	Inactive, Developed in a Prior Year

Validation rating:
☐ High confidence[6]

[6] Credible, reliable, and valid methods for the PIP were documented.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☒ Moderate confidence[7] ☐ Low confidence[8] ☐ No confidence[9] Justification for validation rating: Credible, reliable, or valid methods were implied or able to be established for part of the PIP. The PIP became active December 2020. "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.						
EQRO recommendations for improvement of PIP: • Continue PIP as planned, reporting results not less than quarterly. • Engage in TA with CalEQRO on a regular basis as the PIP progresses.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Review of status of PIP with discussion of how to proceed with performance measures. • The MHP is experiencing problems with retrieving data that the EHR personnel are working to resolve.						

Non-Clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Santa Clara
PIP Title	Beneficiaries' Timeliness to Access and Treatment Services

[7] Credible, reliable, or valid methods were implied or able to be established for part of the PIP.
[8] Errors in logic were noted or contradictory information was presented or interpreted erroneously.
[9] The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

MHP Name	Santa Clara
PIP Aim Statement	"Will this MHP's implementation of weekly capacity/real-time reporting and offer of a warm hand-off between beneficiary and receiving program improve beneficiary access to services from 51 percent to 80 percent within ten business days from the beneficiary's initial date of request?"
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17) * ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): This PIP includes adult/older adult MHP beneficiaries contacting the Mental Health Call Center for mental health services as of FY 2019. These are all Santa Clara County Medi-Cal and uninsured beneficiaries requesting mental health services.	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): The beneficiary participates in a 3-way call between the contract provider/program beneficiary and Call Center Staff to facilitate a warm hand-off for assessment during initial call to request services.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):

PIP Interventions (Changes tested in the PIP)
Warm handoff to occur between Call Center, beneficiary, and the provider. When a beneficiary contacts the Call Center for mental health services; Call Center staff conducts a screening with the beneficiary and then conducts a three-way call to the provider/agency where the beneficiary is being referred. The agency/provider is able to schedule the beneficiary's initial assessment appointment at the initial point of contact with the Call Center (request for mental health services).
Describe the improvement strategy/intervention. Implementation of real-time capacity reporting system (Google Spreadsheet). Clinics/Agencies enter their capacity onto Google spreadsheets in real-time as capacity becomes available at the program level. Each capacity spreadsheet feeds into a larger Google Spreadsheet that is utilized by Call Center staff to send referrals.

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Beneficiaries through Call Center offered first assessment appt. within 10 business days	12/ 2018 - 2/ 2019 (3-month total percent-age) 3/2019-8/2019	51% State assigned this MHP with a CAP based on this percentage result. 3-5/ 2019: 64% 6-8/ 2019: 53%	Began 10/ 2019 ☒ n/a	Not available	☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
Beneficiaries keeping their first	5-7/2019 (3-	56%	Began 10/		☐ Yes ☒ No	☐ Yes ☐ No

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
assessment appt. offered.	month total percentage)	(further information not available)	2019 ☒ n/a			p-value: ☐ <.01 ☐ <.05 Other (specify):
						☒ No test of statistical significance
Programs reporting available slots in real time/weekly frequency in Google Docs	10/11/2019 (Go-live date for new capacity reporting process in Google Docs)	72% (Calculating average compliance by agency, in final reporting week using Unicare)	☒ n/a		☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
						☒ No test of statistical significance
Beneficiaries keeping their first treatment service appointment	5-7/2019 (3-month total percentage)	58% (further information not available)	☒ n/a		☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
					☒ No test of statistical significance	

Was the PIP validated?	☒ Yes ☐ No

Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☐ Baseline year	
☒ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in XX months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active
☐ Planning phase	
☐ Other, inactive	Inactive, Developed in a Prior Year

Validation rating:

☐ High confidence[6]
☒ Moderate confidence[7]
☐ Low confidence[8]
☐ No confidence[9]

Justification for validation rating: Credible, reliable, or valid methods were implied or able to be established for part of the PIP. The PIP became active October 2019.
"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
EQRO recommendations for improvement of PIP: • Assess if there are any new ways appointments are offered and/or kept given COVID-19 restrictions. • Participate in TA with CalEQRO through the completion of this PIP, preferably monthly.						
The TA provided to the MHP by CalEQRO consisted of: • Baseline has been established and the intervention's success is being remeasured for the first year/period. TA included discussion of how to track and report results in a more useful way for the reader of the PIP.						

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written responses to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key ISCA Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the site review.

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Santa Clara	2.75%	1.80%	3.30%	3.73%
Large MHP Group	n/a	2.81%	2.59%	2.88%
Statewide	n/a	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

- ☐ Under MHP control
- ☐ Allocated to or managed by another county department.
- ☒ Combination of MHP control and another county department or agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☒ Yes	☐ No

Business Operations	Status	
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☐ Yes	☒ No
If the BCP status is "No," the MHP uses an Application Service Provider (ASP) model to host the EHR system, which provides 24-hour operational support.	☒ Yes	☐ No
If the BCP status is "Yes," it is tested at least annually.	☐ Yes	☐ No
There is at least one person within the MHP clearly identified as having responsibility for information security.	☐ Yes	☒ No
If no one within the MHP is identified as having responsibility for information security, the parent agency or county IT assume responsibility and control of information security.	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

- A Business Continuity Plan is being developed, but it is unclear if at the MHP level, the Health Agency level, or for the entire county.
- The Chief Information Security Officer is a county-wide position with responsibility for information security.
- It is unclear based on the materials reviewed whether the MHP or Health Agency provide cyber resiliency staff training on potential compromise situations.

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	15%
Contract providers	84%
Network providers	1%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	12	2	0	0
2019-20	10	1	0	1
2018-19	9	2	1	2

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	5	0	0	1
2019-20	5	0	0	1
2018-19	5	0	0	0

The following should be noted with regard to the above information:

- Since no new positions are indicated in Table 16, it is assumed that this reported information does not include the newly created, and filled, position of Director of Analytics and Reporting.

- As the MHP progresses in its implementation of myAvatar, it is encouraging to see new technology resources in Table 15.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by the MHP and does not account for users' log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	677	1100	1777
Clinical Healthcare Professional	1122	0	1122
Clinical Peer Specialist	0	0	0
Quality Improvement	11	0	11
Total	1799	1100	2911

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Large MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	12	37.85
Total EHR Users Supported by IT (Source: Table 17)	2899	2084.00
Ratio of IT Staff to EHR Users	1:241	1:55

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☒ Yes	☐ No
The MHP utilizes an ASP model to support EHR operations.	☒ Yes	☐ No
The MHP also utilizes QI staff to directly support EHR operations.	☒ Yes	☐ No
The MHP also utilizes Local Super Users to support EHR operations.	☒ Yes	☐ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☐	☒	☐	☐
User profile and access setup	☐	☒	☐	☐
Screen workflow and navigation	☐	☒	☐	☐

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☐ Yes ☐ No ☒ Implementation Phase

The rest of this section is applicable: ☐ Yes ☒ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	84
Number of county-operated telehealth sites	14
Number of contract providers' telehealth sites	70
Total number of beneficiaries served via telehealth during the last 12 months	14381
• Adults	7010
• Children/Youth	5971
• Older Adults	1400
Total number of telehealth encounters (services) provided during the last 12 months:	115671

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☐ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☐ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☐ To serve special populations (i.e., children/youth or older adult)
☐ To reduce travel time for healthcare professional staff
☐ To reduce travel time for beneficiaries
☒ To support NA time and distance standards
☒ To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- In FY 2019-20, the MHP indicated they did not use telehealth. This year the MHP does use it as part of their response to COVID-19's impact on

service delivery. The deployment is indicated as still in progress as of December 2020 when the ISCA was submitted to CalEQRO.

- The MHP document labelled “Final Telehealth Comparison Jan-June 2020” has data on the use of telehealth versus “other services” for the MHP’s directly operated and contract providers. In January 2020, there were 6.2 other services for every telehealth service delivered by the MHP. By April 2020, the ratio had flipped to two telehealth services for every other service. That is a very rapid transition for such a large system in just four months.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐	Arabic	☐	Armenian	☒	Cambodian
☒	Cantonese	☒	Farsi	☒	Hmong
☐	Korean	☒	Mandarin	☒	Other Chinese
☐	Russian	☒	Spanish	☒	Tagalog
☒	Vietnamese	☐	n/a		

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
The contract providers that delivered telehealth services across 70 sites were not specifically identified in the documentation uploaded for this desk review	70

Current MHP Operations

- COVID-19 has moved the MHP to rapidly implement network connectivity capability to its employees working from home.
- CBOs have also quickly shifted their service delivery to support employees who work from home, when appropriate.
- The MHP went live with Phase 1 of myAvatar EHR implementation project during September 2020.
- CBOs continue to submit batch files or directly data-enter client data to Pro-Filer system.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SD/MC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Unicare/Pro-file	CBO services, State reporting, capacity management	Harris	18	County TSS
myAvatar Cal-PM	Practice management, Electronic Health Record (EHR), Appointment scheduling	Netsmart	<1	Netsmart
KPI Dashboards	Outcomes	Netsmart	<1	Netsmart
myAvatar Clinical Work Station	Medication Tracking	Netsmart	<1	Netsmart
myAvatar Order Connect	e-Prescribing, Lab Results	Netsmart	<1	Netsmart

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
DCW Perceptive Experience Web Scan	Document Imaging/Storage	Netsmart	>1	Netsmart
Managed Services Organization	Managed Care	Netsmart	>1	Netsmart
Care Coordination Inbox (CCInbox) (3rd Party)	Referral Management, Care Coordination	Netsmart	>1	Netsmart
Netsmart Data Warehouse	Data Warehouse	Netsmart	>1	Netsmart
HealthLink	County services, State reporting, billing, capacity management, assessments, referrals, managed care, inpatient and emergency services	EPIC	2	County TSS
KIDnet	Data Warehouse, Outcomes and State reporting	Advanced Metrics (AMS)	5.5	AMS

Major Changes since Prior Year

- Implementation of myAvatar Clinical Work Station, Order Connect (County Providers), Care Point of View (CarePOV)
- Rapid deployment of telehealth capability in response to COVID-19

The MHP's Priorities for the Coming Year

- Netsmart implementation Phase 2 modules (Managed Services Organization, Provider Connect Enterprise, and Provider Connect NX Portal)

- Telehealth: American Well
- New Sites: Allcove Clinics
- New Sites: Vietnamese American Service Center (VASC)

Other Areas for Improvement

None identified. Plans for Information Systems Change

- New System in place (installed 2020).
- Phase 2 of the myAvatar implementation is scheduled to occur during CY 2021.

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Netsmart/ Clinical Work Station (CWS)	☒	☐	☐	☐
Assessments	Netsmart/ CWS	☒	☐	☐	☐
Care Coordination	Netsmart/ CCInbox	☒	☐	☐	☐
Document Imaging/Storage	Netsmart/ Perceptive	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	Netsmart/ eSignature	☒	☐	☐	☐
Laboratory results (eLab)	Netsmart/ Order Connect	☒	☐	☐	☐

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Level of Care/Level of Service	Netsmart/ CalPM	☒	☐	☐	☐
Outcomes	Netsmart KPI Dashboards	☒	☐	☐	☐
Prescriptions (eRx)	Netsmart/ Order Connect	☒	☐	☐	☐
Progress Notes	Netsmart/ CWS	☒	☐	☐	☐
Referral Management	Netsmart/ CCInbox	☒	☐	☐	☐
Treatment Plans	Netsmart/ CWS	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		12	0	0	0
FY 2019-20 Summary Totals for EHR Functionality:		10	0	2	0
FY 2018-19 Summary Totals for EHR Functionality:		10	0	2	0

Progress and issues associated with implementing an EHR over the past year are summarized below:

- Phase 2 of the myAvatar implementation includes integrating the MHP's myAvatar instance with EHRs used by CBOs. Piloting the implementation with one or two CBOs before attempting to bring them all on the integration platform provides the opportunity to focus on the early adopters, uncover implementation issues, and address them when the impact is small.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	90%	Weekly
Direct data entry into MHP EHR system by contract provider staff	10%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	0%	Choose an item.

The rest of this section is applicable: ☒ Yes ☐ No

Some contract providers have EHR systems, which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Data Transmission from Contract Provider to MHP

EHR Vendor	Product	Count of Providers Supported
Credible	Credible EHR	1
Foothold Technology	EHR	5
Netsmart	myEvolv	2
Netsmart	myAvatar	5
NextGen	EHR	2
Seneca	EHR	1
Welligent	EHR	9
Zencharts	EHR	1

Personal Health Record

The beneficiaries have online access to their health records through a personal health record (PHR) feature provided within the EHR, a beneficiary portal, or a third-party PHR.

☐ Yes ☒ No ☐ Implementation Phase

Not Applicable

Expected implementation timeline:

☐ Already in place	☐ Within 6 months
☐ Within the next year	☒ Within the next two years
☐ Longer than 2 years	☐ n/a

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☐ Yes	☒ No

PHR Functionality	Status	
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☐ Yes	☒ No
View list of current medications through portal.	☐ Yes	☒ No
Have ability to both send/receive secure text messages with provider team.	☐ Yes	☒ No

Medi-Cal Claims Processing

MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

- ☐ Dimension Reports application
- ☒ Web-based application, including the MHP EHR system, supported by vendor or ASP staff
- ☒ Web-based application, supported by MHP or DMC staff
- ☒ Local SQL database, supported by MHP/Health/County staff
- ☒ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☒ Clearinghouse

Table 29 summarizes the MHP's SD/MC claims.

Table 29: Summary of CY 2019 SD/MC Claims

Santa Clara MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**721,866**	**$466,247,348**	**24,937**	**$16,878,322**	**3.49%**	**$449,369,026**	**$212,270,940**
JAN19	66,307	$59,594,745	2,802	$2,496,584	4.02%	$57,098,161	$16,460,639
FEB19	58,929	$51,912,566	2,002	$1,998,273	3.71%	$49,914,293	$14,812,725
MAR19	58,853	$51,915,739	2,010	$1,625,110	3.04%	$50,290,629	$17,929,612
APR19	61,092	$53,083,182	2,295	$1,822,688	3.32%	$51,260,494	$18,112,299
MAY19	64,462	$56,128,211	2,475	$1,646,121	2.85%	$54,482,090	$19,050,568
JUN19	56,224	$49,282,805	1,813	$1,282,168	2.54%	$48,000,637	$16,974,530
JUL19	60,553	$24,276,376	2,437	$1,158,276	4.55%	$23,118,100	$18,383,362
AUG19	60,736	$24,420,555	2,358	$1,114,847	4.37%	$23,305,708	$18,311,676
SEP19	57,707	$23,445,894	1,736	$829,572	3.42%	$22,616,322	$17,822,026
OCT19	66,238	$26,449,029	1,888	$1,035,959	3.77%	$25,413,070	$19,935,302
NOV19	56,414	$23,326,797	1,602	$897,765	3.71%	$22,429,032	$17,686,525
DEC19	54,351	$22,411,449	1,519	$970,959	4.15%	$21,440,490	$16,791,676

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

- Changes in billing rates have impacted ACB information, HCB information, and dollars billed to Medi-Cal. These categories of information are expected to level out in future reports.

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

Santa Clara MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	8,926	$5,697,834	34%
Beneficiary not eligible.	5,828	$3,838,590	23%
Beneficiary not eligible or non-covered charges.	840	$3,158,053	19%
Medicare or Other Health Coverage must be billed before submission of claim.	2,867	$1,816,131	11%
Service line is a duplicate and a repeat service procedure code modifier not present.	2,887	$1,795,292	11%
Total	24,937	$16,878,322	NA

The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.

Denied claim transactions with reason Medicare or Other Health Coverage must be billed before submission of claim are generally re-billable within the State guidelines.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Santa Clara County Behavioral Health, the time and distance requirements are 30 minutes and 15 miles for mental health services, and 30 minutes and 15 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

It was not possible to conduct key informant interviews because of COVID-19 constraints.

Findings

The county MHP met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients

The MHP met the standard for timely access 66 percent for service requests that resulted in an appointment. A Corrective Action Plan (CAP) is required with a submission date requirement of January 2, 2021.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	6
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	11
NPI Type 1 number reported is associated with two or more providers	1
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	2

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	8

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, and DHCS direction for a pause in reviews guidance, no beneficiary focus group was conducted as part of CalEQRO's desk review of Santa Clara MHP this year.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 32 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 32: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	14
The MHP website has access information on the main page that give telephone numbers for mental health, substance use, and suicide crisis hotline telephone numbers for access to services. The website main page includes toggles at the top of the screen to access the information in all six threshold languages. Self-Help Centers (Zephyr and Esperanza) have links along with information related to The Q Corner			

Component		Maximum Possible	MHP Score
(Lesbian, Gay, Bisexual, Transgender, and Questioning -LGBTQ), and the Blackbird House (residential). The BHS Provider Directory is accessible on the main page of the website, along with the MHP beneficiary handbook. The 24/7 call center is prominently presented at the beginning of the Provider Directory. The MHP conducted 24 test calls per quarter in the past year to its access center, 18 of which were in languages other than English. The MHP has successfully pivoted to telehealth for much of the intakes of new beneficiaries during the pandemic. New programs have been impacted in multiple ways by the COVID-19 Public Health Emergency. Field-based programs such as In-Home Outreach Teams (IHOT), Children's Mobile Crisis and ACT/FACT/IFSP have continued to provide in-person, field-based services.			
1B	Capacity Management	10	10
The MHP provided documentation validating the variety of ways that the MHP adapts its capacity to meet beneficiary service needs, both prior to and since the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place. The Cultural Communities Wellness Program (CCWP) is responsible for ensuring that cultural and ethnically competent services are provided to all individuals in need of services. In addition, the program strives to ensure that underserved and un-served populations receive the services they need. Through outreach and engagement activities the program strives to support those individuals who may not seek services due to linguistic, cultural, and/or ethnic barriers. The mobile mental health response team expanded from helping local police to handle crisis to also responding to crisis reported by the public. ACT/FSP/IFSP teams have had some delays in achieving full capacity as some have found that outreach and engagement periods have been more extended than typical. QIC meeting minutes from September 2020 reflect that the MHP is brainstorming project ideas to improve outreach and engagement for adults over 65 years old. The MHP hope to determine whether the decrease in referrals is a result of COVID-19. The MHP hopes to develop culturally and age-appropriate treatment/outreach for this population. The MHP admits that focusing on data for older adults will be a technological challenge.			
1C	Integration and Collaboration	24	24
The MHP has well developed integrated and collaborative programs with partnering agencies and CBOs. Some examples are listed below. The MHP collaborates with other county agencies, including the Department of Rehabilitation, Law Enforcement agencies, Social Services, and the Department of Public Health. As of October 2020, the MHP now has access to dedicated law			

Component	Maximum Possible	MHP Score
enforcement officers when responding to psychiatric emergencies. This is a one-year pilot program, funded by a California Department of Justice grant. The MHP has embedded employees in primary care (FQHCs). Child Welfare Services (CWS) and Juvenile Probation are working with the MHP to create Therapeutic Foster Care (TFC) services. The MHP works with the Public Health Department, in partnership with the Santa Clara County Board of Supervisors, to monitor psychotropic medication use for foster youth.		

Timeliness of Services

As shown in Table 33, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 33: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	14
Per IN 18-011, the MHP has a first offered appointment standard of ten business days for routine outpatient services. The data is tracked for the entire SOC. The standard is met 48 percent of the time overall, with a mean of 4.64 days; adults met the standard 43 percent of the time, with a mean of 4.99 days; children 51 percent of the time, with a mean of 4 days; FC met the standard 38 percent of the time, with a mean of 4.64 days. The MHP is required to submit a Corrective Action Plan for improvement in this metric to DHCS under the Network Adequacy rules. The MHP reports that they are currently unable to track the timeliness of service requests submitted in writing (email or facsimile).			
2B	First Offered Psychiatry Appointment	12	8
In the MATA provided to EQRO, the MHP checked 'No' for the question 'Time to first offered psychiatrist' because the MHP's EMR does not currently have the ability to track offered psychiatry services. To monitor the system, the MHP uses the first psychiatry service instead of the appointment offered while retaining the 15 business days as the standard. Until the EMR is further developed, the MHP will need to use the actual service as a date marker. The MHP is exploring enhancements in the newly stood-up Avatar system to allow for capturing this metric in the future, allowing the MHP to comply with the state timeliness metric as per IN 18-011 to set a standard to offer a psychiatric appointment within 15 business days of request.			

Component		Maximum Possible	MHP Score
The MHP met its standard 37 percent overall, with a mean of 7.77 days; adults met the standard 35 percent of the time, with a mean of 7.28 days, children 38 percent of the time, with a mean of 8.03 days, FC 29 percent of the time, with a mean of 9.00 days.			
2C	Timely Appointments for Urgent Conditions	18	18
The MHP has a 48-hour standard for length of time for urgent appointments that do not require prior authorization and met this standard 100 percent of the time for the entire SOC. The average length of time for urgent appointments was 28 minutes (28 minutes for adults, 32 minutes for children, and 23 minutes for FC youth). The MHP holds all urgent requests to a 48-hour standard. The MHP does record the time of urgent appointment contacts by phone.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	9
The MHP sets the standard as the 7-day HEDIS measure for hospital post-discharge appointments. This data is tracked for the entire SOC, including all hospitals, separately for adult, children, and FC. The standard is met 49.8 percent overall, with a mean of 5.7 days; adults met the standard 41.6 percent of the time, with a mean of 6.4 days; children 73.5 percent of the time, with a mean of 4.3 days; FC met the standard 78.2 percent of the time, with a mean of 5.2 days. While this data shows improvement in timeliness, it has not yet met the MHP's internal standard of 75 percent. The MHP continues to address this issue.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
The MHP had 1,594 hospital admissions in FY 2019-20 with 154, or 10.2 percent readmitted within 30 days overall; adults 1,180 admissions with 100, or 8.9 percent readmitted within 30 days; children 414 admissions with 54, or 13.9 percent readmitted within 30 days; FC 94 admissions with 14, or 16.1 percent readmitted within 30 days. The FY 2020-21 QIC work plan provides structure to track and review this metric.			
2F	Tracks and Trends No-Shows	10	10
The transition to Avatar no-show information is not reflected in the current MATA and will be a follow-up item for next year's EQRO review now that Avatar is tracking this metric. The reported no-show rate for psychiatrists and clinicians is slightly higher than last year, but still so low that it suggests under-reporting. The MHP implemented myAvatar in a way to assure that all no-show and cancellations can be recorded and reported on throughout engagement with the beneficiaries.			

Component	Maximum Possible	MHP Score
The MHP has a standard for no-shows for both psychiatrist and clinicians other than psychiatrists of 10 percent. The no-show for psychiatrists is listed as 0.2 percent overall and for clinicians other than psychiatrists at 6.2 percent.		

Quality of Care

In Table 34, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 34: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	12
The MHP reviews and updates the Cultural Competence Plan (CCP) annually, including quantifiable goals and objectives with routine (at least quarterly) review of data tracking and trending. The MHP has a Behavioral Health Board Cultural Competency Advisory Committee which meets once per month. The Quality Assurance Performance Improvement (QAPI) work plan reports that the percentage of providers able to communicate in each of the threshold languages of the county exceeds the percentage of that language in the population of beneficiaries served. The MHP provided documentation of culturally competent service delivery and of collaboration with various groups within the county. Several dashboards were provided showing various cultural elements that the MHP tracks. Documentation provided to CalEQRO describes services to all threshold populations.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	10
The MHP utilizes a formal process to assess LOC, to include Child and Adolescent Needs and Strengths (CANS) and Milestones of Recovery Scale (MORS) instruments. The MHP developed an IST for the call center to help with placing the beneficiary into the most appropriate LOC at the time of initial request for services. The MHP implemented a new best practice strategy of integrating the DLA-20 into the treatment plan, moving to telehealth and in-person services, virtual work and			

Component		Maximum Possible	MHP Score
meetings, and an adapted version of the American Society of Addiction Medicine (ASAM) bio-psycho-social assessment. The MHP continues to research reasons for beneficiaries remaining in care for extended periods when they are viewed as clinically ready to step down to the next level of care. Addressing this issue is more complex during the COVID-19 Public Health Emergency due to telehealth services bringing a new set of issues in delivering services. The MHP initiated monthly check-in meetings with MHP programs (including direct county and certified contractors) in response to the need to support and track services. It was found during these meetings that Transition Age Youth (TAY) were hesitant to transition after they met their treatment goals. The MHP is reviewing options to resolve this issue while continuing to give needed support to TAY beneficiaries.			
3C	Quality Improvement Plan	10	10
As of December 2019, the MHP passed federal network certification requirements with an approved corrective action plan. BHSD will continues to monitor provider ratios and timeliness to access to meet beneficiary needs. The MHP provided the QAPI work plan which contains measurable goals and objectives and includes an annual evaluation of prior year findings and results. Quarterly meeting minutes and agendas were provided to EQRO. The work plan describes populations served. Progress on objectives is reported at the QIC meetings.			
3D	Quality Management Structure	14	14
The MHP has a designated QM unit that interfaces with other MHP units and activities. A new BHSD Executive position over Analytics & Reporting has been filled. New Business Intelligence and Data Analyst positions are being filled, and a portion of the BHSD analyst workforce has been re-aligned to report under this position. The Decision Support Unit provides support to the Behavioral Health Services Department by research and analysis of data collected by the system. Data entered in the Behavioral Health Services Department's management information system (MIS) is routinely analyzed to help the system make informed data driven decisions. Decision Support also utilizes data from other sources such as the bi-annual Consumer Perception Survey (CPS) and data used to track the Full-Service Partnership (FSP) Programs to provide relevant information. New data collected from the MORS and Client Informed Outcome Measures (CIOM) is being incorporated into the reporting structure to assist the Department in the improvement of service delivery. The MHP provided QIC minutes to validate a direct line of communication between the QI coordinator, QI staff, and the administrative leadership staff. The minutes also reflect participation from CBOs.			

Component		Maximum Possible	MHP Score
3E	QM Reports Act as a Change Agent in the System	10	10
The MHP provided documentation to validate that QM reports are used to monitor service access, timeliness, quality of care, and outcomes. The MHP uploaded QM reports included timeliness, no-shows, referrals, discharges, Crisis Stabilization Unit (CSU), and hospital emergency admission. Some dashboards were broken down into adults, children, FC youth. MORS dashboard tracking time spent in services (minutes) with beneficiary versus their MORS value. The MHP uploaded a spreadsheet which tracks homelessness statistics (e.g., pre-housed versus housed beneficiaries and reviewed hospitalization days, residential LOS, incarcerations, etc.). Both current PIPs address timeliness issues that are tracked by QM reports. The QIC minutes show workgroups that are created to address quality and performance concerns provided through data results.			
3F	Medication Management	12	12
The MHP tracks and trends HEDIS and other national measures related to diagnoses, medication practices and care standards. The MHP has a psychiatric pharmacist who is actively engaged in medication monitoring and creates an annual report. The MHP has policies, procedures, and programmatic practices to ensure minimum psychiatric service frequency, follow-up standards, and guidelines for medication use. Santa Clara County Public Health Department, in partnership with the Board of Supervisors, provides a public health nurse to monitor psychotropic medication prescriptions and use for foster youth. The Public Health Department, Social Services Agency Department of Family and Children's Services (DFCS), Behavioral Health Services Department, and Juvenile Probation Department (JPD) have worked collaboratively over the past few years to address this issue comprehensively.			

Beneficiary Progress/Outcomes

In Table 35, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 35: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	16
The MHP utilizes a variety of beneficiary outcome measures, to include DLA-20 as a functional outcomes and LOC tool for adults/older adults. Implementation for CCPs will coincide with the Phase 2 of myAvatar Go-Live. MORS and Patient Health Questionnaire (PHQ-9) are used in primary care and behavioral health to manage transfers between the two services. CANS-50 and the Pediatric Symptom Checklist-35 (PSC-35) are utilized as LOC tools and to determine placement and treatment duration for children and youth. These tools and others as appropriate, are used in treatment planning as well as tracking beneficiary progress. The MHP compiles and present reports, at least annually, of beneficiary outcomes by program to address potential gaps among subpopulations and to identify where quality improvement is needed.			
4B	Beneficiary Perceptions	10	9
The MHP administered the May 2020 Consumer Perception Survey (CPS). DHCS cancelled the second CPS for CY 2020 due to response to the COVID-19 Health Care Emergency and the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place making it difficult for beneficiaries to be surveyed in a sufficiently representative way of all subpopulations. QIC meeting minutes from September 2020 reflect the MHP is experiencing a noticeable increase in quality-of-care grievances. They compared the last three years but were unable to identify a reason for the increase in grievances. There was more than one telehealth survey conducted with beneficiaries, with varying results. The MHP conducted a telehealth survey in April 2020, over 93 percent of beneficiaries reported they were satisfied with telehealth services and would prefer to use them for their follow-up visit. A number of contracted agencies conducted their own telehealth surveys and obtained similar results. QIC meeting minutes from September 2020 reflect that the MHP administered a beneficiary survey (adult, caregiver, and family) regarding telehealth (13 questions). The survey was administered throughout various programs via survey monkey, with 90 percent of the returned surveys from adults, and three percent from caregivers. The results showed decreasing satisfaction with telehealth services, with one reason stated being difficulty with internet connectivity. Consumer Family Member (CFM) Focus Groups were not possible during this review, and therefore no verbal input from beneficiaries on beneficiary perceptions is included here.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	10
Zephyr and Esperanza Self-Help Centers are peer-driven, staffed by peers, and managed by MHP staff. Activities have been suspended during the pandemic;			

Component	Maximum Possible	MHP Score
however, are due to resume virtually via Microsoft Meetings in mid-January 2021. The MHP staff have reached out to members via phone contact during this time, but contact has been limited. According to the director at Zephyr, most center participants are active and interested in the many self-help groups and activities. When open, the Centers offer Wellness and Recovery Action Planning (WRAP), men's and women's support groups, computer labs, specific topics such as "Healthy Boundaries" and the "Journey of Self," along with social activities. Centers are open to adults 18 and over. The MHP reports that they inform beneficiaries about these programs and monitor their utilization. MHP states that a Request for Proposal (RFP) to add a third site was not successful; however, there are currently two Self-Help Centers open to all.		

Structure and Operations

In Table 36, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 36: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	30
The MHP offers all specialty mental health services per their DHCS contract. Self-Help Centers Zephyr and Esperanza, The Q Corner (LGBTQ drop-in center), and the Blackbird House (residential) are peer run. New programs have been impacted in multiple ways by the COVID-19 Public Health Emergency. While the volume of outpatient services generally decreased during the early months of Shelter in Place, and there have been episodic challenges in parts of the service system during surge periods, the overall volume of services appears to have stabilized. The MHP has established and implemented strategies for stepping beneficiaries down to or supporting beneficiaries in maintaining their mental health treatment in non-specialty levels of care in an effort to improve transitioning of mild-to-moderate beneficiaries once stabilized. "Pay for Success" is an intensive case management program that identifies the high utilizers of the mental health system and refers these individuals to Telecare for intensive case management. If clients pass the screening randomization process, they are then referred to Telecare intensive case management program.			

Component		Maximum Possible	MHP Score
The MHP engaged in two PIPs in the past year: one is ongoing from the previous year and one is in the implementation phase. Both are active currently.			
5B	Network Enhancements	18	18
Due to the Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, most MHP services (directly operated and CCPs) have turned to telehealth to provide a significant portion of their services. Prior to this, the MHP was beginning to explore options for telehealth. As the MHP pivoted to telehealth, several difficulties had to be overcome, including ensuring that staff had proper equipment (e.g., laptops, cameras), that the new EMR (Avatar) contained the proper telehealth location codes, documents (consents, etc.), and overall knowledge to successfully conduct telehealth visits. Clinicians had to learn to describe the risks and benefits of telehealth and to help clients problem-solve connectivity, equipment, and privacy challenges. The MHP provided numerous guidance documents which were compiled and published into a Telehealth Guide. Utilizing telehealth has had a beneficial effect on engagement, with the MHP noting a steady decline in the no-show rate since telehealth implementation. The MHP continues to explore strategies to increase beneficiary access to appropriate telehealth technology. Additionally, the MHP is preparing to go live with American Well, a telehealth solution integrated with myAvatar. In April 2020, Uplift Family Services was awarded a contract for Mobile Response and Stabilization Services (MRSS) for children and youth to begin in January 2021. The Whole Person Care Committee includes the MHP as a stakeholder.			
5C	Subcontracts/Contract Providers	16	14
The MHP holds quarterly contractor provider meetings. Meeting minutes from November 2020 indicates attendance from Catholic Charities (30 were invited). The Adult/Older Adult, criminal justice services, family and children, cross system initiative, and supportive housing departments were also in attendance. QIC meeting minutes reflect CBO presence and participation. The MHP provided dashboards which included contract providers information. The MHP is in discussions with Valley Health Plan (VHP) regarding the enhancement of their mild-to-moderate network inclusive of strategies to ensure that the correct entity (MCO versus MHP) is billed for care. Transition in care continues to be an area of opportunity for the MHP. (See responses to Recommendations 3 and 5). The MHP continues to address this issue with progress but not resolution currently.			
5D	Stakeholder Engagement	12	12

Component		Maximum Possible	MHP Score
The MHP held 11 tele-town hall meetings to address "COVID-19 and Your Mental Health." The panel in each session included one to two mental health experts and peer support workers with lived experience. Tele-town halls are provided for all groups in-house and within the community. The MHP provided documentation that stakeholders are invited to the quarterly QI meetings and PIP meetings. Zephyr and Esperanza Self Help Centers, and Blackbird House Respite Center, are run by Peers. The Q Corner, LGBTQ Drop-in Center is run by peers and supported by community members. This EQR was a desk review; therefore, there were no stakeholder focus group sessions held to assess stakeholder perceptions on the issue of engagement.			
5E	Peer Employment	8	8
Peer employment is offered through the MHP and with CCPs. Positions exist at the Self-Help Centers (Zephyr and Esperanza), the Q Corner Drop-In Center, Blackbird House Residential Respite Center, and within the various clinics. Currently, there is only one code for peers (i.e., Peer Support Worker). Peer Support Workers are the only positions available to beneficiaries/family members (supervisors at the Self-Help Centers are MHP staff). The MHP has indicated that they have intentions to pursue an advanced level (career ladder) for peer employees, but such efforts have not produced results as of the time of this review. It was reported last year that Zephyr has a working relationship with the Department of Rehabilitation. The MHP has an extensive list of training resources available to peers on their website. The MHP also sponsors a Peer Intern Program aimed at providing training opportunities for beneficiaries and/or family members in support of their entry/reentry into the workforce. The MHP has a formal collaboration with the Department of Rehabilitation, local colleges, and adult education programs. Due to the nature of the desk review, no peer focus group session was possible and therefore their perceptions were not available to be included in this report.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Santa Clara MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Access to Care

Changes within the Past Year:

- In April 2020, Uplift Family Services was awarded a contract for MRSS for children and youth to begin January 2021.
- Three 4-person IHOTs were launched (one county-operated and two contracted) to provide services throughout the County.
- The Mission Street Sobering Center was re-designed to dedicate half of its capacity (ten of twenty total beds) to the new Mental Health Triage Center Unit. These chairs have been used to successfully divert emergency psychiatric services (EPS), psychiatric inpatient, and jail admissions.
- Beginning November 2020, the Virtual You: Navigating Wellness Online program began providing prevention-focused practices for youth ages 12 to 25. Two program sites (San Jose/Palo Alto) serve as stand-alone, integrated, “one-stop-shop" health centers for young people to access prevention and early intervention (PEI) mental health services, physical health, employment and school support, and screening and referral for substance use services.
- The MHP developed an IST for the call center to help with placing the beneficiary into the most appropriate LOC at the time of initial request for services.
- To refine LOC determinations at assessment, the MHP has implemented the DLA20 which can be used both as an outcomes and LOC tool for adults/older adults.

Strengths:

- The MHP went from delivering one telehealth service for every 6.2 services delivered by other modes in January 2020 to delivering two telehealth services for every one service by other modes in June of 2020. This is something the MHP can be justly proud of as an accomplishment in the interest of quality service delivery.
- Based on the report "Final Telehealth Comparison Jan-June 2020," it appears the number of services delivered each month declined slightly in February 2020 from the January level and then rose significantly over the next three months. This is a preliminary count, but it suggests that the MHP was able to sustain its level of service during the early days of the COVID-19 pandemic.
- Behavioral Health Treatment Court expanded from one to two judges this year due to the high volume of cases. The team grew to include eight Court Assessors, with staff (who speak English, Spanish and Vietnamese) completing approximately 2000 screenings annually.
- Overall penetration rates have increased by 19 percent between CY 2017 (5.17 percent) and CY 2019 (6.16 percent.)

Opportunities for Improvement:

- None noted.

Timeliness of Services

Changes within the Past Year:

- The MHP has two active PIPs which both address timeliness to service.

Strengths:

- The new Avatar system has the capability to record and report no-show and cancellations throughout engagement with the beneficiaries. This will resolve the MHP's inability to track this metric effectively.

Opportunities for Improvement:

- Access to follow-up appointments after hospitalization reported on the MATA shows improvement in timeliness; however, it has not yet met its internal standard of 75 percent. The MHP continues to address this issue.
- In MHP's Assessment of Timely Access provided to EQRO, the MHP checked 'No' for the question 'Time to first offered psychiatrist' because the MHP's EMR does not currently have the ability to track offered

psychiatry services. To monitor the system, the MHP uses the first psychiatry service instead of the appointment offered while retaining the 15 business days as the standard. The MHP is exploring enhancements in the newly stood-up Avatar system to allow for capturing this metric in the future.

Quality of Care

Changes within the Past Year:

- The MHP launched new intensive and step-down programs (ACT/FACT/FSP/IFSP and WARMS) during CY 2020.
- During the latter half of CY 2020, BHSD worked to reorganize clinical and administrative functions to support integration of MH and Substance Use Treatment Services (SUTS). This project will continue through CY 2021.
- BHSD QA Department did not conduct all annual Clinical Record Reviews for all contracted and county operated outpatient programs because of COVID-19 restrictions and additional duties the Public Health Emergency required of all staff.

Strengths:

- Both the 7-day and 30-day follow-up visit rates are four percentage points above the state average.
- Rehospitalization rates, whether measured at 7-days or 30-days, have declined by six percentage points between CY 2018 and CY 2019 while outpatient follow-up rates for both time periods have increased slightly.

Opportunities for Improvement:

- For FY 2019-20 there has been a slight decrease on meeting standards of completed consent forms. Each quarter the percent of incomplete charts remained the same (50 percent) through the fiscal year.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP implemented a new best practice strategy of integrating the DLA-20 into the treatment plan.

- An adapted version of the American Society of Addiction Medicine (ASAM) bio-psycho-social assessment was integrated into the assessment tool.

Strengths:

- None noted.

Opportunities for Improvement:

- None noted.

Foster Care

Changes within the Past Year:

- In October 2019, two new Katie A. Intensive Services providers launched their programs. The COVID-19 county-wide response has impacted the ramp up of these programs as there has been some difficulty with one provider agency with hiring new staff. The MHP reports that they were not impacted as there continues to be ample capacity in the program with no waiting list for services.

- The MHP has made some procedural changes to the Pathways to Well-Being" behavioral health screening process quickly and adeptly with the county's shelter in place order issued in March 2020. This did not impact timeliness or service delivery, as staff were quickly able to adjust to teleworking and completing all processes remotely.

Strengths:

- Following the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place and the county wide-response to the Health Emergency, Katie A. Intensive Services providers adapted quickly to begin using telehealth as clinically appropriate and whenever possible. Children and youth who needed in-person support for crisis or emergency needs were provided with such, and as the pandemic continued, providers became more skillful in providing services via telehealth and balancing services with some in person support as needed. As families and staff have become more comfortable and adept with social distancing and using personal protective equipment (PPE), there is now an opportunity for more services to be in-person.

Opportunities for Improvement:

- The MHP is not currently tracking and trending aggregate data due to a current data validation that is underway in the database. The MHP plans for this issue to be resolved in the next few months.
- The MHP does not track and trend aggregate data for the PSC-35.
- Service providers, including both MHP-operated clinics and contracted agencies, may utilize data from the PSC-35 at the beneficiary level to assist with assessment, treatment planning, and tracking progress. However, the MHP has had difficulty with collecting data during the restrictions placed due to COVID-19 restrictions.

Information Systems

Changes within the Past Year:

- The MHP and DMC-ODS Go-Live for Clinical Work Station was September 2020.

Strengths:

- As the MHP progresses in its implementation of myAvatar, it is encouraging to see two new technology resources listed in the ISCA.
- The Santa Clara County TSS Strategic Plan states that they have 119 “modern and specialized position classifications,” which will likely aid in hiring for specific skill sets.
- Santa Clara County TSS is building a robust training and development program called TSS University to ensure that employees can retain and grow their skills throughout their careers. This has the potential of a positive impact on employee retention.
- The MHP is planning to implement Netsmart’s ProviderConnect Enterprise to facilitate electronic data exchange with contract providers.
- The MHP’s website is easy to navigate and informative. It also provides useful COVID-19 coverage.

Opportunities for Improvement:

- Even with the two new technology full time equivalent (FTE) positions, the MHP’s technology resources support a much higher number of users per person than other large counties. The MHP is encouraged to reevaluate the adequacy of its resources in this area as the December 2021 end of the Netsmart engagement approaches.

- The Santa Clara Health Care Agency Information Technology (HCA IT) 3-Year Strategic Plan 2018-2020 states “HCA IT needs to consider the need for and development of an advisory group consisting of leaders from IT, program and administrative services to provide review and advice on IT opportunities and direction.”
- The HCA IT 3-Year Strategic Plan 2018-2020 provides an extensive vision of where HCA would like to be in the future, but it does not follow up with any time-bound steps to get to that vision. It is a thoughtful and informed document but would benefit from linking the vision to concrete actions.

Structure and Operations

Changes within the Past year:

- The past year has included fires in Santa Clara and surrounding counties and the pandemic health emergency, both of which have pulled MHP staff for emergency responses through the year.
- Changes in staffing and organization in the past year included (not a complete list):
    - New Executive Director of Behavioral Services Department for MH and SUDS
    - New QM Director
    - Director of Analytic Reporting hired in March 2020 (create, formulate, visualize of all data, connecting data, creating dashboard, reports and works with the CBOs).
    - Internal Department reorganization of Quality Management-integrating mental health and SUD quality improvement to streamline efforts. No change for contractors.
- The MHP has been in the process of standing up Avatar EHR, which included many new forms, (e.g., a new assessment and discharge summary.)
- As noted in Table 22, Summary of MHP Telehealth Services**,** the MHP has 84 telehealth sites active at this time, 14 are county-operated and 70 are contract provider sites.

Strengths:

- The MHP continues to deliver all services required by their contract due to their ability to assess the unprecedented situation of the past year and be

flexible in how they pivoted to telehealth and other changes to address the situation.

- The MHP served 14,381 beneficiaries via telehealth in the past 12 months, with 115,671 discrete encounters provided.

Opportunities for Improvement:

- The number of telehealth encounters provided in languages other than English in the last 12 months was not available at the time of the review.

FY 2020-21 Recommendations

PIP Status

None noted.

Access to Care

None noted.

Timeliness of Services

Recommendation 1: Track and trend data that Avatar captures for the metric of time to first offered psychiatrist appointment following request for service.

Recommendation 2: Continue to address beneficiary access to follow-up appointments after hospitalization with a goal of meeting the standard of 75 percent.

Quality of Care

Recommendation 3: Track the number of telehealth encounters provided in languages other than English, trend, and report services according to languages.

Beneficiary Outcomes

None noted.

Foster Care

Recommendation 4: Following the completion of the current data validation in the database, implement tracking, trending and reporting aggregate data for CANS-50.

Recommendation 5: Consider the benefit of tracking, trending and reporting aggregate data for the PSC-35.

Information Systems

Recommendation 6: Pilot myAvatar integration with CBO EHRs with one or two CBOs before bringing on the entire group of providers to address implementation issues when the impact is relatively small and more easily managed.

Structure and Operations

None noted.

SITE REVIEW PROCESS BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, and DHCS direction for a pause in reviews guidance, in oversight activities, it was not possible to conduct an on-site or remote platform external quality review of the MHP. The entire review was a desk review of documents provided by the MHP to CalEQRO. Consequently, some areas of the review were limited, and others were not possible (e.g., conducting beneficiary focus groups).

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Data

Attachment D: ACA Penetration Rates and ACBs

Attachment E: ACB Range Distributions

Attachment F: List of Commonly Used Acronyms

Attachment A—Review Agenda

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

Santa Clara
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Peer Inclusion/Peer Employees within the System of Care
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Supported Employment Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Electronic Health Record Hands-On Observation
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Angela Kozak-Embrey, Quality Reviewer
Kiran Sahota, Quality Reviewer
Robert Greenless, Information System Reviewer
Deb Strong, Consumer-Family Member Reviewer

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and in preparing the recommendations within this report.

MHP Review Sites and Participants

This review was a desk review conducted through documents provided to the EQRO by the MHP due to COVID-19 restrictions.

No participants were interviewed due to desk review status of the CalEQRO review of Santa Clara MHP.

Attachment C—Approved Claims Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Attachment D—ACA Penetration Rates and ACBs

Table D1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table D1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Santa Clara MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Large	1,791,890	69,726	3.89%	$372,190,347	$5,338
MHP	119,097	5,826	4.89%	$45,223,015	$7,762

Attachment E—ACB Range Distributions

Table E1 shows the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Table E1: CY 2019 Distribution of Beneficiaries by ACB Range

Santa Clara MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	21,682	89.48%	93.31%	$115,982,425	$5,349	$3,998	53.02%	59.06%
>$20K - $30K	1,150	4.75%	3.20%	$27,867,648	$24,233	$24,251	12.74%	12.29%
>$30K	1,400	5.78%	3.49%	$74,889,958	$53,493	$51,883	34.24%	28.65%

Attachment F—List of Commonly Used Acronyms

Table F1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
AB	Assembly Bill
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
ANSA	Adult Needs and Strengths Assessment
ANSI	American National Standards Institute
API	Asian/Pacific Islander
ASAM	American Society of Addiction Medicine
BAL	Beneficiary Access Line
BHC	Behavioral Health Concepts
BHIN	Behavioral Health Information Notice
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
CANS	Child and Adolescent Needs and Strengths
CBO	Community Based Organizations
CBT	Cognitive Behavioral Therapy
CCC	Cultural Competency Committee
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIO	Chief Information Officer
CMS	Centers for Medicare and Medicaid Services

Acronym	Full Term
COVID-19	Corona Virus Disease-2019
CPM	Core Practice Model
CPS	Client Perception Survey
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CURES	Controlled Substances Utilization Review and Evaluation System
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based Program or Practice
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FTE	Full Time Equivalent
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Full Term
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HR	Human Resources
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IHBS	Intensive Home-Based Services
IMD	Institution for Mental Diseases
IN	Information Notice
IOT	Intensive Outpatient Treatment
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
KPI	Key Performance Indicator
LCSW	Licensed Clinical Social Worker
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Care
LOS	Length of Stay
LPHA	Licensed Practitioner of the Healing Arts
MAT	Medication Assisted Treatment
MCO	Managed Care Organizations
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MFA	Multi-Factor Authentication
MHBG	Mental Health Block Grant
MHP	Mental Health Plan
MHSA	Mental Health Services Act

Acronym	Full Term
MHST	Mental Health Screening Tool
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MSO	Management Services Organization
NA	Network Adequacy
n/a	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NTP	Narcotic Treatment Program
OON	Out-of-Network
OTP	Opioid Treatment Program
PA	Physician Assistant
PDSA	Plan Do Study Act
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PIN	Personal Identification Number
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RFP	Request for Proposal
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration

Acronym	Full Term
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SD/MC	Short-Doyle Medi-Cal
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
STCs	Special Terms and Conditions
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TPS	Treatment Perception Survey
VOIP	Voice Over Internet Protocol
WET	Workforce Education and Training
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan